BHSF Form LNHA-7
04/2019

RightFAX Cover and Transmittal Log

This fillable form MUST accompany all documents submitted

To: LDH/Medicaid Fax Number: (225) 389 - 8019

Pages (including cover): _____ MEDICAL RECORDS attached (Y or N): _____

DATES:

Initial Contact Date:	
Interview Date:	
Transmittal Date:	

NURSING FACILITY INFORMATION:

Nursing Facility Satellite Name:	
Nursing Facility Satellite Location ID:	

NURSING FACILITY TRUSTED USER INFORMATION:

Nursing Facility Trusted User Name:	
Nursing Facility Trusted User ID:	
Nursing Facility Trusted User Phone:	
Nursing Facility Trusted User Email:	

APPLICATION INFORMATION: (Please fill in as much information as possible)

Applicant Name:	
Applicant Date of Birth:	
Applicant Social Security Number:	
Application ID:	
Case ID:	

NOTES:
